

REEMPLOYMENT ASSISTANCE

P.O. Box 4730, Aberdeen, SD 57401

Fax: 605.626.3172

raclaims.sd.gov

PUA CLAIMANT: BACKDATE AND LATE FILING REQUEST

CLAIMANT NAME: _____ SSN: _____

Current Effective Date of Claim: _____ Backdating Requesting Start Date of (must be a Sunday): _____ BACKDATE REQUEST ONLY
Effective date is on your monetary determination *The Sunday after the first week*

SECTION A:	Week Ending Date: (Saturday)	_____	_____	_____
		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
During the week that ended in that date in the row above, did you work for an employer or in self-employment? (If yes, add information for each employer on Pg. 2)	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If no, skip to Section B (Starts with Holiday Pay)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If no, skip to Section B (Starts with Holiday Pay)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If no, skip to Section B (Starts with Holiday Pay)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If no, skip to Section B (Starts with Holiday Pay)</i>
Total number of hours you worked during the week (with all employers or self-employment):	_____ hrs	_____ hrs	_____ hrs	_____ hrs
Gross wages earned in dollars and cents (If self-employed, use NET)	\$ _____	\$ _____	\$ _____	\$ _____
If worked but had no earnings, was it because you attempted commission sales, were self-employed, or have other unpaid hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Are you still working?	<input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION B Did you or will you receive any of the following for this week?				
<i>HOLIDAY PAY?</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>
<i>VACATION PAY OR ANNUAL LEAVE?</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>
<i>SICK PAY?</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>
<i>SEVERANCE PAY/WAGES IN LIEU OF NOTICE?</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, gross amount</i>

Will you begin receiving pension, disability payments or workers' compensation or did the amount previously reported change?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>
Are you on call to return to work for your regular employer?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Were you physically and mentally able to work?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>
Were you available to accept a job if offered?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>if no, explain in remarks</i>
Did you refuse any offer of work or referral to work?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, explain in remarks</i>
Did you begin school or did your class schedule change during the week?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
For each week, identify the reason(s) that best describe your situation from the list on the next page (Section C). If "Other" (M) add reason on page 2.			

You are responsible for reading and knowing the information in your claimant handbook about benefit eligibility. Attempting to claim or receive benefits by entering false information could mean a loss of benefits, fine, and imprisonment. Please note you are agreeing to have your responses become part of your account record and the information you provide may be verified through matching programs. Do you understand? YES NO

CERTIFICATION: I certify that my statements are true and correct and I am aware of the penalties for all false statements on my claim.

Claimant's Signature _____ **Date:** _____

To e-sign this form, you will need to open it in an Adobe Reader (not a web browser) OR use your mobile device OR Print and sign in ink. Sending instructions are on Page

Section C Reason that best describes your situation during the week requesting should be entered in the last box on

Page 1.

- A** = You tested positive or you are experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- B** = A member of your household tested positive for COVID-19.
- C** = You are providing care to a family member or member of your household who has tested positive for COVID-19.
- D** = You are the primary caregiver for a child or other person who is unable to attend school or another care facility that is closed as a direct result of COVID-19 and the school or facility is necessary in order for you to work.
- E** = You are unable to reach your place of employment because of a quarantine imposed as a result of COVID-19
- F** = You are unable to work because you have been advised by a health care provider to self-quarantine because of COVID-19.
- G** = You were scheduled to start a job and now do not have that job or are unable to reach that job because of COVID-19.
- H** = You have become the breadwinner or major support for a household because the head of household has died because of COVID-19.
- I** = You have to quit your job because you were diagnosed with COVID-19 by a qualified medical professional, and although you no longer have COVID-19, the illness caused health complications that render you objectively unable to perform essential job functions, with or without a reasonable accommodation.
- J** = Your place of employment closed because of COVID-19.
- K** = Your employer reduced your hours of work because of COVID-19.
- L** = You are self-employed or an independent contractor and now unable to work because COVID-19 has severely limited your ability to continue performing your customary work activities.
- M** = Other:

Section D If you have worked during this week, complete the information below. If you need more employers, use the remarks box.

Employer Name: _____ Still Working? YES NO

Worked: _____ hrs for week: _____ (week end date) And _____ hrs for week: _____ (week end date). And _____ hrs for week: _____ (week end date)

Wages: Hourly Rate: _____ Total Wages (including tips): _____

Employer Address: _____

Employer Name: _____ Still Working? YES NO

Worked: _____ hrs for week: _____ (week end date) And _____ hrs for week: _____ (week end date). And _____ hrs for week: _____ (week end date)

Wages: Hourly Rate: _____ Total Wages (including tips): _____

Employer Address: _____

REMARKS: Reason for requesting backdating or late payment request. (Attach additional sheet if necessary):

Send Completed Form to:

Mail
DLR RA Benefits
PO Box 4730
Aberdeen SD 57402-4730

Email: DLRRAClaims@state.sd.us

**Note there are two R's in this email address*